Transition of Care – Things to Consider Prior to Hospital Discharge

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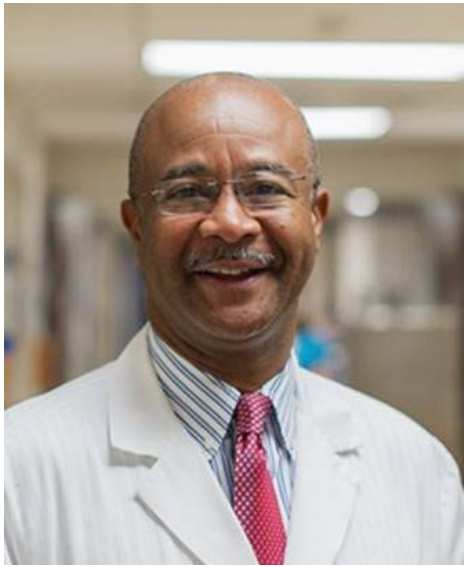
Today's Presenter



Tadarro Richardson, M.D., SFHM

Dr. Richardson has over 35 years of experience practicing medicine and leading successful teams. He earned his medical degree from the University of Louisville and completed both his internship and residency at University Hospital Cincinnati. Tadarro is a diplomate of the American Board of Internal Medicine. He is a Senior Fellow of Hospital Medicine.

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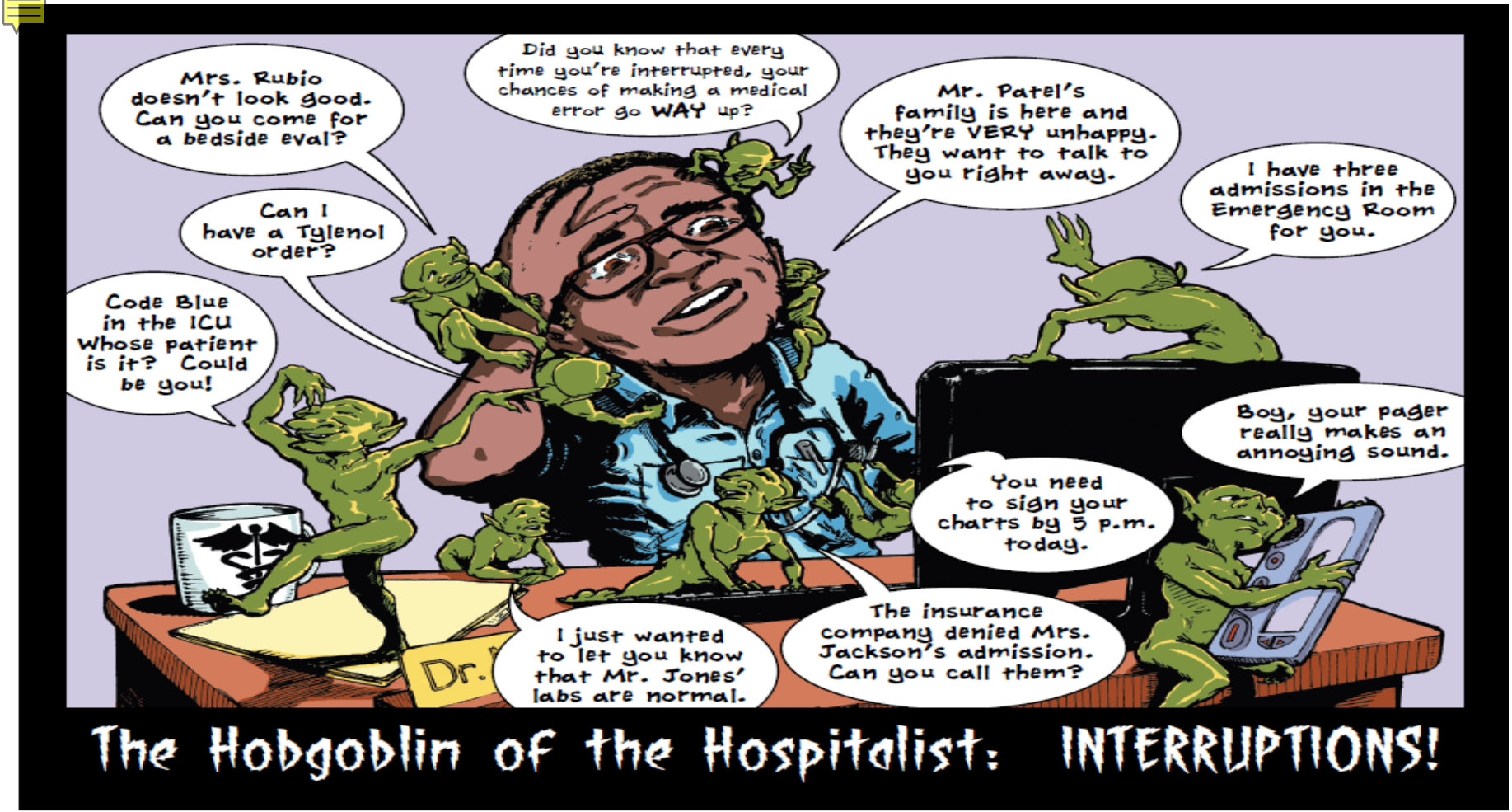


From Today's Hospitalist –Leo Motter, MD

My Objectives

To clarify what the Hospital Teams can do to assist with a safe and effective discharge

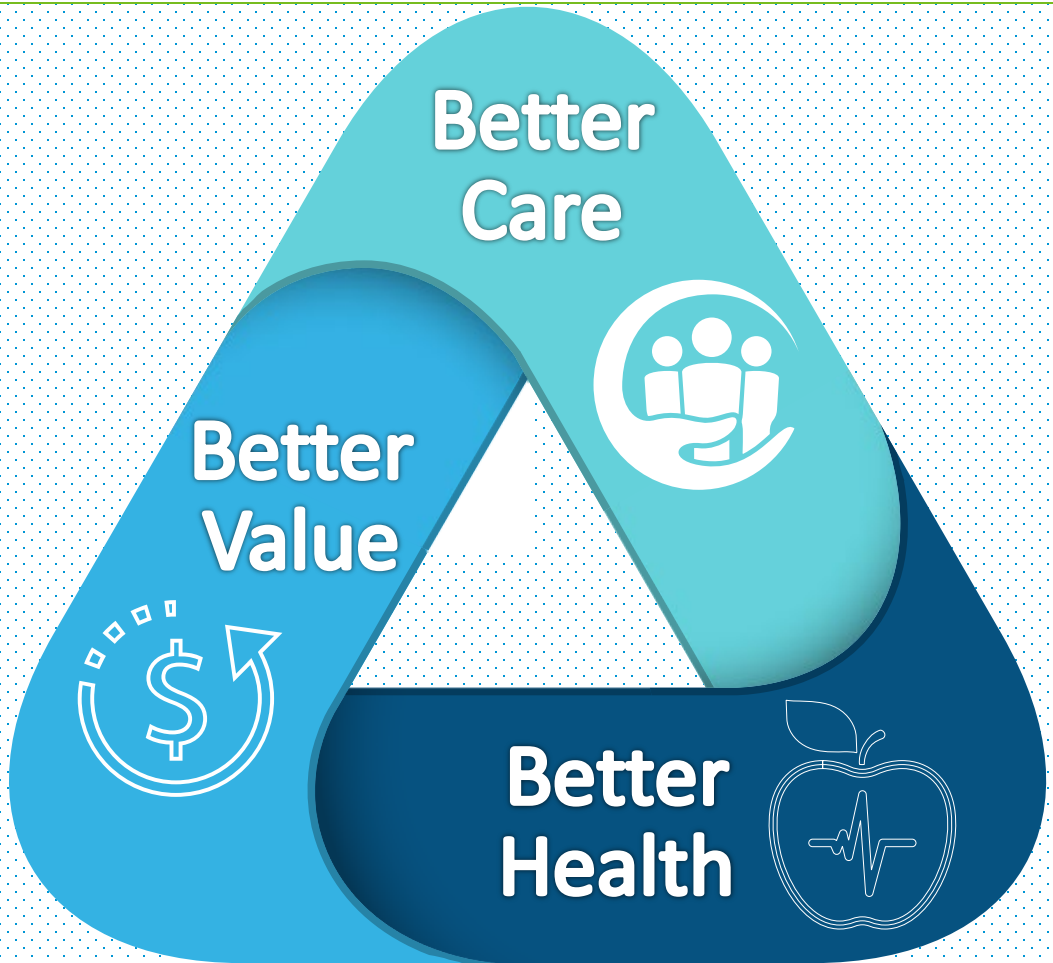
To highlight the barriers and challenges that occur when an individual is discharged

To present some of the KPIs (key performance indicators) that are routinely monitored in the PAC space

To present information that will allow you to better evaluate the environments that a patient is discharged to

Why am I involved in Post Acute Care

Institute for Healthcare Improvement Triple Aim



The Role of the Hospitalist

Looking for the Triple AIM

- As opposed to traditional FFS care, Value Based Care is taking the forefront.
- The Hospital Medicine and PAC Teams must involve themselves with discussions about all aspects of care including medical, economic, psychological and social.

The Six Domains of Healthcare Quality from the IOM

What's the problem with Transitions of Care?

- 35 million annual discharges
- Everybody does it differently
- In all settings multiple handoffs can occur and the more handoffs, the greater the chances of critical information that's lost.
- The receiving entity may not have access to the records of the sending entity.

What options do we have in Post-Acute Care

- Home with or without home health
- Nursing Home (ECF)
- SNF – Skilled Nursing Facility
- IRF
- LTAC

What's the Difference?

- Home – What can we do at home?
- ECF – NH – provides long term care.
- SNF – requires a qualifying event – i.e., 3-night stay; requires at least 1 hour/day of therapy. There are also "super snfs" which boast specialty care and advanced technology to accommodate the sicker patient.
- IRF – Strokes/Prosthetic devices who need intensive PT/OT/ST and usually the care of a Physiatrist; needs 3 hours/day of treatment; usually seen by a physician at least 3x/week.
- LTAC – sick and complicated patients e.g., Vents/Trach/PEG/LVAD/Chest Tubes who will require at least 25 days of intensive monitoring.

Case Presentation – Ms. Jones

- 75 yo white female; widowed and lives alone at her home. Limited family contact though the daughter is known to be the POA.
- Hypertensive, Diabetic, mild COPD with 20+ pack years; she gets routine checkups.
- Post Cholecystectomy for stones
- BP controlled; HgA1c 8.5; Creatinine 1.4
- Norvasc 5 mg daily/Lipitor 20 mg daily/Glucophage 500 mg daily/prn albuterol inhaler
- Presented with chest pain secondary to anterior MI; arrested in the ER and required intubation and pressors. PCI successful for single vessel occlusion. Prolonged stay in the ICU with prolonged ventilator support. Successfully weaned and transferred to the floor. She was found to have muscular atrophy, and decreased sensation. Seen by PT/OT. Neurology consult was requested. Mildly decreased LVEF on echocardiography.
- Case management is suggesting discharge to home with a HH aide and outpatient PT/OT
- Patient response “I know I can’t take care of myself at home right now and there is no one to help me.”

You are the provider of record

- You are the hospital provider taking care of this patient. You are on a 7 on/ 7 off schedule working Monday – Sunday. You pick up the Ms. Jones on Monday. She has been in the hospital for 6 days prior to your starting your rotation. On Friday afternoon you are notified that the patient can be discharged on Monday.

What are the discharge recommendations

- It's Sunday. Ms. Jones is up at bedside. No chest pain/VSS/sugars under excellent control. The insurance company had notified case management on Friday that dc to a 1-star SNF on Monday is authorized or she may go to her home with home health.
- Discharged on Crestor 20 mg/day, metformin ER 500 mg bid, metoprolol tartrate 25mg BID, ASA 81 mg daily, Plavix 75 mg daily, enalapril 5 mg twice daily and sliding scale insulin tid.
- Recommendations are to fu with Cardiology in 2 weeks post discharge and with the primary MD in 3-4 weeks.
- What's next?

Where would you send this patient?

- Home
- Nursing home (ECF)
- SNF – Skilled Nursing Facility
- IRF - Inpatient Rehabilitation Facility
- LTAC – Long term acute care facility

- Check any that may apply.

Where would I send this patient?

Home - Possibly

Nursing Home (ECF!) - No

SNF – Possibly

IRF – May not be sick enough

LTAC – Not sick enough

True or False…….

There is benefit in terms of mortality and functional status when a patient is sent to a nursing home (skilled nursing facility) vs. home.

Does it really matter?

False.

There were no significant differences in 30-day mortality rates or improved functional status when comparing home vs. skilled nursing home facility.

Discharge to home was associated with a 5-6 percentage point higher rate of readmission at 30 days compared with discharge to a skilled nursing facility.

JAMA Intern Med. 2019 May; 179(5): 617–623 Patient Outcomes After Hospital Discharge to Home With Home Health Care vs to a Skilled Nursing Facility

What is/are the next steps in preparation for the discharge

- Begin preparing the discharge summary in anticipation of discharge tomorrow.
- Notify the family of anticipated discharge.
- Consider changing the medication regimen.
- Make sure in the orders that a 2-week fu appointment with Cardiology is made prior to discharge.

Click any that may apply.

Discharge Planning to a Nursing Home

- Ms. Jones is discharged to the SNF on Monday. She arrives to her destination at 6 PM, shortly after the departure of the attending MD. Based on CMS guidelines, how soon following admission is the doctor required to see this individual?

- 24 hours
- 72 hours
- 1 week
- 1 month

CMS GUIDELINES

- Under 42 C.F.R. §483.40(c)(1), the initial comprehensive visit must occur no later than 30 days after a resident's admission into the SNF. Further, under 42 C.F.R. §483.40(c)(4) and (e), the physician may not delegate the initial comprehensive visit in a SNF. Non-physician practitioners may perform other medically necessary visits prior to and after the physician's initial comprehensive visit.

Centers for Medicare & Medicaid Services (CMS)

How do you communicate?

- Written
- Face to Face
- Phone to Phone
- Protected email or text
- Dictated discharge summary
- Time Frame for the communication

Documentation in the Discharge Summary

- Hospital course summary:
  - All active diagnoses that caused the admission
  - All chronic, co-morbid, complicating, secondary diagnoses
  - NO signs/symptoms: Instead, use probable/most likely Dx's
  - Listing of ALL medications, note any changes or additions
  - Any significant lab and imaging test results that need post discharge follow up
  - All pending lab and imaging test results that need post d/s follow up
  - Disposition and follow up plans
  - Summary of patient education

What are the factors influencing her discharge..other than medical?

- Economic factors – can medication be afforded? Does insurance provide coverage for home care or care at a post-acute care facility?
- Psychological factors – will the individual comply with going to somewhere other than home? Is she comfortable in her home environment?
- Social factors – specifically what is the support to ensure safety at home e.g., family support, transportation for office visits

The Stigma of the Nursing Home

- The average age of participants when they moved to a nursing home was about 83. The average length of stay before death was 13.7 months, while the median was five months. Fifty-three percent of nursing home residents in the study died within six months.

J Am Geriatric Soc. 2010 Sep; 58(9): 1701–1706.

What's happening around the country?

- "Taking into account a variety of patient and facility-level factors, initial assessments occurred later, or not at all, in SNFs that were small, rural, and in the South or Midwest compared to their larger, urban, suburban and Northeastern counterparts. Patients with cognitive impairment were also more likely not to have a SNF visit and were seen later, on average, than those without cognitive impairment."

- *Health Affairs* – April 1, 2019

Star ratings:

- Medicare has a 5-star rating system to define care delivery in the nursing home. What are the metrics?
- Affiliation with a Joint Commission Accredited Hospital
- A certified medical director (CMD) who oversees patient care
- Quality
- Health Inspections
- Staffing ratios

Click all that apply.

Star ratings

- Medicare has a 5-star rating system to define care delivery in the nursing home. There are 3 criteria.
- Quality – Broken into short- and long-term metrics
- Health Inspections – often based on complaints and inspections
- Staff turnover – relates to nursing, physical therapists and administration

Challenges in the SNF and ECF

- Limited staff and frequent turnover
- Limited ability to run codes
- Lab is typically done off site
- There is limited subspecialty coverage; but there is usually the availability of behavioral health, podiatry, and wound care.
- Provider coverage may be limited

Challenges in the Nursing Home Setting

"the staffing levels of skilled nursing in NHs helps determine NH mortality rates. NH effectiveness in preserving life expectancy would be improved if both the quantity and quality of skilled nursing care were enhanced.

Life expectancy in nursing homes Pages 1877-1888 | Published online: 03 Oct 2021 Applied Economics Robert J. Brent

What are the common causes for hospital readmission from PAC?

- We cannot prevent readmissions. People are going to get sick.
- However, studies have suggested that approximately 25% of readmissions may be preventable
- The sicker the patient, the more likely she/he will be readmitted (> 6 comorbidities) [1]
- Polypharmacy > 5 medications and High-Risk Medications
- Medication reconciliation errors
- Falls in the facility
- Timely follow-up
- Poor understanding of advanced care planning

The financial impact of Hospital Readmissions

- In 2018 there were 3.8 million all cause adult readmissions. The average readmission cost was $15,200.

Statistical Brief #278 AHRQ July 2021

Screening Tools for assessing readmission Risk

- 8 Ps
- LACE Index
- HOSPITAL
- These tools may help in identifying individuals who are at highest risk for readmission, thus allowing us to direct care and resources to these individuals.
- Remember that social, economic and psychological factors have a huge role in impacting these tools.

The 8 P for assessing readmission risk

- Problems with medications
- Psychological
- Principle Diagnosis
- Physical limitations
- Poor health literacy
- Patient Support
- Prior hospitalization
- Palliative Care

Compliments of SHM Project BOOST (Better Outcomes for Older Adults through Safe Transitions)

LACE INDEX SCORING TOOL

- Length of stay
- Acuity of admission
- Comorbidities
- Emergency Department Visits

HOSPITAL SCORING INDEX

- H emoglobin
- O ncology unit discharge
- S odium level at discharge
- P rocedure during hospitalization
- I ndex T ype
- A dmission number for 1 year
- L ength of Stay

Infection in the Nursing Home

The most common cause of bacteremia in the Long-Term Care facility is:

UTI

C. Diff

Cellulitis

Pneumonia

What is the Beers Criteria

- Methodology for evaluating a patient's risk of 1 year mortality
- Methodology for assessing one's fall risk
- Methodology that assists providers in avoiding potentially harmful medications
- Methodology for assessing the risk for pressure ulcers

What you need to know about the Beers Criteria

- 1991 – Mark Beers, MD, Geriatrician
- He helped champion a reference tool now called the Beers Criteria
- It addresses potentially inappropriate medication use in older adults
- Updated every 3 years since 2011.

Five categories of medications in the Beers Criteria

- Those that are potentially inappropriate
- Those to be avoided in certain conditions
- Drugs to use with caution
- Drug-Drug interaction
- Dosage adjustment with renal compromise

Under prescribing can also be problematic.

In the post acute care world, the providers are held accountable when the patient is on multiple medications > 5-6. Although we work diligently to limit the number of medications, it should always be at the providers discretion to prescribe what is necessary to deliver exemplary care. Once again, we look at the example of Ms. Jones. She was sent home on multiple medications, all of which were medically necessary.

How do we hit the triple AIM?

- An updated advanced care plan is invaluable.
- Knowing the capabilities of the facility that you're sending your patient to
- Medication reconciliation i.e., medications on admission, and medications on discharge. This will allow the PAC provider to better facilitate discharge back to home.
- A simple drug regimen using medications that are given once daily (when appropriate)
- When possible, avoid hypnotics and anti-psychotics. These meds lead to falls.
- Notification of any/all pending studies. A study has suggested that ~ 40% of discharged patients have pending tests at the time of discharge.

https://www.uptodate.com/contents/hospital-discharge-and-readmission/abstract/24

Items to consider when discussing Advanced Care Plans

- Cardiac Resuscitation
- Life Support
- Tube feeding
- Blood transfusion
- Surgery
- Dialysis
- Antibiotics and Medications
- Pain Medication even if it results in temporary addiction or hastens death
- 99497 (16-30 minutes) and 99498 is each additional 30 minutes

And what do I want you to remember?

- Advanced Care Planning
- Star rating – Use Nursing Home Compare to look it up.
- Discharge summary with medication reconciliation, and the H/P. It's always nice to have these in hand even prior to the patient's arrival to the PAC destination.
- All pending laboratory including radiographs. Tests that need to be ordered. Tests ordered on the day of discharge are problematic.
- Prophylactic basics….pneumonia/flu/covid vaccines when appropriate

And what do I want you to remember?

- A discharge to home leads to a higher readmission rate; it does not however impact mortality or improvement in functionality.
- Polypharmacy is bad; but so is under prescribing. Do what is medically necessary.
- A simple drug regimen with QD/BID dosing is optimal. Please do this when you can.
- Place limit/stop orders on antibiotics, anticoagulants, SS insulin, PPIs when appropriate. Give me some clues as to GDR (gradual dose reduction) aka deprescribing. Let me know when to remove the staples.

And what do I want you to remember?

- Please make appointments with consultants prior to discharge. It's often much easier for the hospital to do this, rather than have the patient or the receiving facility do this.
- Consider aligning with a defined set of SNFs and allow those providers to have read only access to the medical records of the patients sent to them.
- Educate and communicate with your patient

KPIs (Key Performance Indicators) in the PAC Environment

- Advanced Care Planning
- Polypharmacy
- High Risk Drugs (e.g., hypnotics, anti-psychotics, antihistamines)
- Depression Screening
- Vaccinations
- UTIs
- Pressure Ulcers
- Falls
- Return to Hospital

Hospital to Post-Acute Care Transfer Form

INTERACT®
Version 3.0 Tool

A. Patient Information

Name _____

DOB _____/_____/_____ Gender: ☐ M ☐ F

Language: ☐ English ☐ Other _____

Race/Ethnicity: ☐ White ☐ Black ☐ Hispanic ☐ Other _____

B. Family/Caregiver/Proxy Contact

Family/Caregiver Name _____

Tel (_____) _____

Healthcare Proxy/Guardian Name *(if different)* _____

Tel (_____) _____

C. Advance Directives/Goals of Care

☐ Full Code ☐ DNR ☐ DNI (Do Not Intubate)

☐ DNH (Do Not Hospitalize) ☐ No Artificial Feeding ☐ Comfort Care

☐ Hospice Care

☐ Other *(specify)* _____

Were goals of care discussed during this hospitalization? ☐ No ☐ Yes *(specify)*

_____

Patient decision making capacity? ☐ Capable of making decisions

☐ Requires proxy

D. Transferring Hospital Information

Hospital _____

Unit _____

Discharging RN _____

Tel (_____) _____

Discharging MD _____

Tel/Page (_____) _____

Date of Admission to Hospital _____/_____/_____

E. Post-Acute Care Information

Transfered to _____ Tel (_____) _____

Nurse to Nurse verbal report? ☐ No ☐ Yes *(specify to whom)* _____

F. Hospital Physician Care Team Information

Primary Care Physician *(or Hospitalist)* _____ Tel (_____) _____

Specialist _____ Specialty _____ Tel (_____) _____

Specialist _____ Specialty _____ Tel (_____) _____

G. Key Clinical Information

Vital Signs Time Taken _____ Pain Rating _____ ☐ N/A Pain Site _____

Temp _____ BP _____ HR _____ RR _____ O2 Sat _____ Weight _____

Mental Status ☐ Alert ☐ Disoriented, follows commands ☐ Disoriented, cannot follow commands ☐ Not Alert

Diagnoses Primary Discharge Diagnosis _____

Other Medical Diagnoses _____

Mental Health Diagnoses _____

H. High Risk Conditions/Treatment Information *(check all that apply)*

☐ Fall Risk Precautions: _____

☐ Heart Failure: ☐ New diagonsis? ☐ Exacerbation this admission? Date of last echo _____/_____/_____ ☐ EF_____% Dry Weight *(if known)* _____

☐ Anticoagulated: Reason: ☐ Afib ☐ DVT/PE ☐ Mech. Valve ☐ Post-OP ☐ Low EF ☐ Other _____

Duration _____ Goal INR: ☐ 1.5 -2.5 ☐ 2 -3 ☐ Other _____

☐ On PPI: Indication(s): ☐ In-hospital prophylaxis and can be d/c ☐ Specific Dx: _____

☐ On Antibiotics: Indication(s): _____ Total Treatment Course _____ days Date started _____/_____/_____

☐ Diabetic: Most recent glucose Date _____/_____/_____ Time (am/pm) _____

(Please attach list of recent values if available)

I. Procedures &Key Findings *(during this hospitalization)* * Please Attach Reports *

List Procedures *(surgeries, imaging)* _____

_____

_____

Key findings _____

_____

_____

J. Medications and Allergies

☐ Medication List Attached

Please provide a HARD COPY PRESCRIPTION FOR CONTROLLED SUBSTANCES

Allergies: ☐ None known ☐ Yes *(specify)* _____

Pain med: ☐ No ☐ Yes *(specify)* _____

Dose _____

Last Dose (am/pm) _____

Nursing Home Capabilities List

INTERACT®
Version 3.0 Tool

Capabilities	Yes	No
Primary Care Clinician Services		
At least one physician, NP, or PA in the facility three or more days per week	Y	N
At least one physician, NP, or PA in the facility five or more days per week	Y	N
Diagnostic Testing		
Stat lab tests with turnaround less than 8 hours	Y	N
Stat X-rays with turnaround less than 8 hours	Y	N
EKG	Y	N
Bladder Ultrasound	Y	N
Venous Doppler	Y	N
Cardiac Echo	Y	N
Swallow Studies	Y	N

Capabilities	Yes	No
Nursing Services		
Frequent vital signs *(e.g. every 2 hrs)*	Y	N
Strict intake and output (I&O) monitoring	Y	N
Daily weights	Y	N
Accuchecks for glucose at least every shift	Y	N
INR	Y	N
O2 saturation	Y	N
Nebulizer treatments	Y	N
Incentive spirometry	Y	N
Interventions		
IV Fluids *(initiation and maintenance)*	Y	N
IV Antibiotics	Y	N

Consultations

Psychiatry	Y	N
Cardiology	Y	N
Pulmonary	Y	N
Wound Care	Y	N
Other Physician Specialty Consultations *specify:*	Y	N

Social and Psychology Services

Licensed Social Worker	Y	N
Psychological Evaluation and Counseling by a Licensed Clinical Psychologist	Y	N

Therapies on Site

Occupational	Y	N
Physical	Y	N
Respiratory	Y	N
Speech	Y	N

IV Meds – Other *(e.g. furosemide)*	Y	N
PICC Insertion	Y	N
PICC Management	Y	N
Total Parenteral Nutrition (TPN)	Y	N
Isolation *(for MRSA, VRE, etc…)*	Y	N
Surgical Drain Management	Y	N
Tracheostomy Management	Y	N
Analgesic Pumps	Y	N
Dialysis	Y	N
Advanced CPR *(ACLS capability)*	Y	N
Automatic Defibrillator	Y	N

Pharmacy Services

Emergency kit with common medications for acute conditions available	Y	N
New medications filled within 8 hours	Y	N

Other Specialized Services *(specify)*

THANK YOU

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